If you are concerned that your child has a feeding problem, please complete this form by checking the boxes and review it with the doctor

IMFeD for children
Identification and management of feeding difficulties

Child's name _____ Child's height _____ (cm)

Child's age _____ Child's weight _____ (kg)

Date _____ Child's head circumference _____ (cm)

1. Does your child have any of the following symptoms? (check all the boxes ☑ that apply)

- a. ☐ a. Choking or pain with swallowing
- b. ☐ b. Weight loss
- c. ☐ c. Vomiting
- d. ☐ d. Diarrhea
- e. ☐ e. Blood in stool
- f. ☐ f. Food allergies
- g. ☐ g. Eczema or hives
- h. ☐ h. Asthma
- i. ☐ i. Frequent infections
- j. ☐ j. Delayed development

2. Check the box next to the description that most sounds like your child

☐ **a. My child**
- Gets hungry, readily begins eating but then pulls back and refuses to continue

☐ **b. My child**
- Eats a limited number of foods
- Refuses foods because of smell, taste, texture, temperature and/or appearance
- Only accepts foods prepared in a specific way
- Is reluctant to try new foods

My child has a poor appetite, and (check the box or boxes that best apply):

☐ **c. My child**
- Was small at birth or premature
- Has one or both parents who are small or grew slowly
- Seems healthy and active

☐ **d. My child**
- Is not interested in food
- Stops eating after a few bites
- Constantly tries to get out of the high chair or to leave the table
- Enjoys playing and interacting with familiar people

☐ **e. My child**
- Is withdrawn and irritable
- Does not smile, babble, or talk much
- Shows little interest in playing

☐ **f. My child**
- Cries at the sight of food or feeding device (eg, bottle, spoon, or high chair)
- Is intensely resistant to feeding
- Started refusing food after a frightening feeding experience such as choking or vomiting
- Is or was tube-fed and fears eating

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3. Please provide the following information:

Height of child's mother _____

Height of child's father _____

Was the child born premature? ☐ Yes ☐ No

If yes, how many weeks into the pregnancy was the child born? _____

Did either of the child's parents experience delayed puberty or slow growth as a child? ☐ Yes ☐ No

If yes, which parent? _____

4. Does your child eat:

Fruits? ☐ Yes ☐ No

If yes, which ones? _____

Vegetables? ☐ Yes ☐ No

If yes, which ones? _____

Meats or meat alternatives (e.g. tofu, soy beancurd, nuts, beans)? ☐ Yes ☐ No

If yes, which ones? _____

Dairy products? (e.g. milk, cheese, yogurt)

☐ Yes ☐ No

If yes, which ones? _____

Grains or other starchy foods? ☐ Yes ☐ No

If yes, which ones? _____

Do Not Write In This Section—For Office Use Only

Weight-for-age percentile _____

Height-for-age percentile _____

Weight-for-height _____

Projected height at 20 years of age if child continues to grow along current height-for-age percentile:

_____

Midparental height calculations:

Boys:

(_____ + _____) ÷ 2 = _____

Dad's height (cm) Mom's height (cm) +13

Girls:

(_____ + _____) ÷ 2 = _____

Dad's height (cm) –13 Mom's height (cm)

Midparental height - Projected height at 20 years

= _____

Is difference >5 cm? ☐ Yes ☐ No